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TAJIKISTAN
FAMILY PLANNING SITUATION ANALYSIS 2007

The Europe and Eurasia Regional Family Planning Activity

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ACRONYMS

AKF	Aga Khan Foundation
BHBP	Basic health benefit package
CME	Continuing medical education
CLMIS	Contraceptive logistics management information system
DS	Demographic survey
EU	European Union
FD	Family doctor
FP	Family planning
GDP	Gross domestic product
IDU	Injecting drug user
IUD	Intrauterine (contraceptive) device
JSI	John Snow, Inc.
LAM	Lactational amenorrhea method
LMIS	Logistics management information system
MC	Mercy Corps
MICS	Multiple indicator cluster survey
MOH	Ministry of Health
ob/gyn	Obstetrician/gynecologist
OC	Oral contraceptive
PHC	Primary health care
PSI	Population Services International
RH	Reproductive health
RHCS	Reproductive health and contraceptive security
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VFS	Voluntary female sterilization
WRA	Women of reproductive age (15-49 years)

SUMMARY

Following the breakup of the Soviet Union, Tajikistan suffered the severest economic declines among the former Soviet Republics, exacerbated by the civil war of 1993–1997. During the past five years, Tajikistan has experienced some economic recovery, achieving an economic growth rate of 10.6 percent in 2004 that dropped to 6 percent in 2006. With a gross national per capita income of just $ 1,260 purchasing power parity, Tajikistan remains among the lowest income countries in the world[1] and has the poorest health outcomes of all the countries in the region. In 2005, approximately two thirds of the population lived below the poverty level.

TEN BEST FAMILY PLANNING PRACTICES IN THE EE/EA REGION

To better understand the situation in Tajikistan, the Activity reviewed progress against ten regional best family planning policy and program practices. This list is based on the 2005 Senlet and Kantner report, "An Assessment of USAID Reproductive Health and Family Planning Activities in the Eastern European and Eurasian Region," a recent literature review on global best family planning practices and programs, and field interviews in selected countries participating in USAID's Europe and Eurasia Regional Family Planning Activity program. These best practices include:

1. **Liberalized provision of FP services.** National health regulations require that family planning counseling and services are readily available through a range of health professionals, including not only obstetricians and gynecologists, but also family doctors, general practitioners, pediatricians and nurse/midwives.
2. **Family planning counseling, services, and contraceptives are part of the Basic Health Benefit Package**. At the primary health care level contraceptives are provided to all women, regardless of ability-to-pay. A mix of different types of contraceptives are part of the country's Essential Drug List.
3. **Up-to-date and evidence-based policies, regulations, standards, guidelines and supportive supervision systems are in place to ensure the quality of family planning services at all levels of health care:**
    a) **Service providers –** A **c**ompetency-based national qualification system is in place that allows health professionals to provide quality family planning counseling and services;
    b) **Up-to-date national regulations set minimum standards** for health facilities, equipment, commodities and infection prevention;
    c) **National guidelines and protocols for family planning counseling and service delivery** are evidence-based, widely available and updated regularly;
    d) **Effective quality assurance and supportive supervision systems** are in place to ensure the quality of family planning services and strengthen provider performance and support, especially at the primary health care level;
    e) **National health protocols** require that postpartum and post-abortion women are offered family planning counseling, methods and services**;**
    f) **Breastfeeding and the Lactational Amenorrhea Method (LAM)** are promoted as family planning methods.

[1] http://siteresources.worldbank.org/ICPINT/Resources/Atlas_2005.pdf.

4. **A broad range of family planning methods are available, accessible, affordable, and acceptable** in both rural and urban areas.
5. **Special programs are in place that are designed to meet the needs of vulnerable target groups**, such as adolescents, internally displaced persons (IDPs), new urban migrants, prostitutes, and the very poor.
6. **Family Planning is part of pre- and in-service training programs for health care providers.** This includes the pre-service training programs in medical universities and technical schools for nurses, as well as in-service training for continuing medical education for doctors and in-service training for re-licensing health professionals, including midwives and nurses.
7. **Contraceptive security is ensured through adequate planning within the government,** guided by a well-functioning Logistics Management Information System (LMIS) that enables targeting of subsidized contraceptives and efficient supply chain management of all contraceptive commodities throughout the country.
8. **Adoption of a "culture" that promotes family planning counseling,** where providers and clients engage in frank and regular conversation about sensitive reproductive health issues and family planning and appropriate services are offered.
9. **Family planning is actively promoted through social marketing and behavior change/social mobilization efforts**, including wide distribution of quality informational materials for clients and "job aids" for providers.
10. **A well-functioning national health management information system** collects, analyses and uses FP data to monitor progress and evaluate and improve program effectiveness.

Tajikistan has made some progress in strengthening the family planning in several areas. However, much remains to be done. The following table describes Tajikistan 's progress against the ten family planning best practices described above.

Summary Table of Tajikistan Situation Analysis

Best Practices	Existing Situation	Needs Improvement
#1: Liberalized provision of FP services	• Family doctors and midwives allowed to provide FP only at pilot sites • Only ob/gyns allowed to provide contraceptives at most sites	• Limited cadre of FP service providers, especially in rural areas
#2: Family planning counseling, services, and contraceptives are part of the Basic Health Benefit Package	• Basic health benefit package includes FP counseling and free condoms, hormonal contraceptives and IUD	• Data suggests that FP services are not provided according to the basic health benefit package and clients pay for "free" FP services

#3: Up-to-date and evidence-based policies, regulations, standards, guidelines and supportive supervision are in place	• Updated evidence-based national guidelines available	• No supervision or strategy by the Ministry of Health to ensure dissemination and adherence to guidelines • Restrictive policies and regulations limit type of health facilities that can provide FP services
#4: A broad range of FP methods are available, accessible, affordable, and acceptable in both rural and urban areas	• A wide variety of methods are available through commercial sector • UNFPA-donated commodities are available at public facilities • Use of LAM	• Most commercial products are unaffordable to majority of the population • Chronic stock-outs of contraceptives in public sector, particularly in rural areas • Negative perceptions of hormonals widespread among service providers • Lack of availability of VSC
#5: Special programs are in place designed to meet the needs of vulnerable target groups	• Condoms available for groups at risk for HIV • EU-funded services for youth, migrants, and other vulnerable populations in 3 districts	• RH/FP services for vulnerable groups is limited
#6: Family planning training is part of pre-and in-service training program for health care providers	• Some FP counseling and service delivery training modules in family doctors' re-training curricula	• No evidence- or competency-based FP training in pre-service education in medical universities • No functioning continuous medical education system • No evidence-based FP teaching for nursing and midwifery students
#7: Contraceptive security is ensured through adequate planning within the government	• Contraceptives included in essential drug list • UNFPA-funded pilot LMIS is available in two oblasts	• No Government contraceptive security strategy or plan to provide financial support for contraceptive commodities • Chronic stock outs of contraceptives due to the weak distribution system, including the leakage and management weaknesses • No national LMIS
#8: Adoption of a "culture" that promotes FP counseling	• Government support for reproductive health services	• Lack of competency-based training and supervision to improve counseling services
#9: FP is actively	• Some social marketing of	• No national IEC/BCC and social

promoted through social marketing and behavior change/social mobilization efforts	condoms aimed at vulnerable groups	mobilization efforts
#10: A well-functioning national health management information system collects, analyzes and uses FP data.	• Service statistics collected to produce annual Health Status Report.	• No efficient health management information system • Available data not used to improve or expand FP services

I. PURPOSE AND METHODOLOGY

PURPOSE

This review of the FP situation in Tajikistan was conducted as part of the USAID-funded Europe and Eurasia Regional Family Planning Activity. The Activity is a regional effort with the goal to leverage best practices in family planning to accelerate program implementation across the region and, ultimately, to increase modern contraceptive use and decrease abortion rates.

This desk review is designed to:

- Assess factors that affect family planning service delivery in Tajikistan;
- Identify and document supportive policies and best practices in family planning program implementation;
- Propose recommendations for scaling up best family planning practices and new interventions to improve program effectiveness and increase utilization of modern contraception.

This Tajikistan review is one in a series of situation analyses in the Europe and Eurasia region of the FP environment in priority countries chosen base on need, opportunity, and Mission interest in the regional activity. Each review provides a country background, with a special focus on describing the health care system and the status of reproductive health; describes each of ten best practices as they relate to the particular country context; and provides recommendations for focusing further interventions and resources.

METHODOLOGY

In order to systematically assess the family planning situation in each of the priority countries, the Europe and Eurasia Regional Family Planning Activity team began by reviewing Senlet and Kantner (2005), "An Assessment of USAID Reproductive Health and Family Planning Activities in the Eastern European and Eurasian Region." The team then identified a list of ten FP policy and program best practices based on the Senlet and Kantner assessment report, a literature review on global best FP practices and programs, and field interviews. The team conducted a review of available documents and an Internet search to obtain additional information on country

background, policies, and programs in family planning. Those interviewed in Tajikistan are listed in Annex III.

This review is a summary of the generally available literature with qualitative input from key stakeholders in country. The review's intention is to serve as a basis for discussion of country and regional priorities for FP program improvement, based on the best available information. It is not intended as a comprehensive analysis of the country situation, but rather as a brief "snapshot" of this particular point of program development to guide future programming. Data included in this report are valid through the first quarter of 2007. Due to rapidly changing circumstances in the country, some information may have already changed.

II. BACKGROUND

COUNTRY CONTEXT

Following the breakup of the Soviet Union, Tajikistan suffered the severest economic declines among the former Soviet Republics, exacerbated by the civil war of 1993–1997. By 1998, the country's real gross domestic product (GDP) was estimated to have contracted to just one third of its 1991 level. During the past five years, with the return to peace and political stability, Tajikistan has experienced some economic recovery, achieving an economic growth rate of 10.6 percent in 2004. This growth rate then dropped to 8 percent and 6 percent in 2005 and 2006, respectively. With a gross national per capita income of just $ 1,260 purchasing power parity, Tajikistan remains among the lowest income countries in the world[2] and has the poorest health outcomes of any of the countries in the region. In 2005, about two thirds of the population was living below the poverty level[3].

Of the country's population of 6.5 million, more than 42 percent are children under age 15. An estimated 1 million Tajiks migrate externally for work. Approximately 80 percent of these migrants are males aged 15–49 years.[4]

Tajikistan is administratively divided into three oblasts and 41 districts.

HEALTH CARE SYSTEM

The government's annual expenditure on health services is less than US$ 1 per capita.[5] These services—delivered through public-sector health facilities—are generally of low quality. The Ministry of Health's (MOH) capacity to oversee the system and reform, regulate, and control the overall quality of service delivery is very limited. The World Bank supported the launch of health care reforms in Tajikistan in 2000 with the introduction of a family medicine-based primary health care (PHC) system in several pilot districts.

Affordability of health services is a major problem for the population. Most health care expenditures in the country are private and informal, including out-of-pocket payments for ostensibly free products and services in the public sector and the purchase of drugs in pharmacies.

[2] http://siteresources.worldbank.org/ICPINT/Resources/Atlas_2005.pdf.
[3] http://www.usaid.gov/policy/budget/cbj2006/ee/tj.html.
[4] Tajikistan Demographic Survey 2002.
[5] World Bank Community and Basic Health Project, report No: 34019. 2005.

According to a World Bank-sponsored survey, in 2003, about 57 percent of poor households did not seek health care when necessary because they could not afford it. In an effort to ensure availability and affordability of high-quality drugs for all, a number of donors have explored the use of revolving drug funds. In 2004, the government defined and approved a guaranteed national basic health benefit package (BHBP), which provides free services for vulnerable population groups. The majority of BHBP-covered services are delivered at the PHC level.

REPRODUCTIVE HEALTH

Over the past decade, Tajikistan had a significant decrease in population growth from 3 percent in 1990 to 0.9 percent in 2006. This may be largely attributed to major out migration and partly to a decline in fertility. The average desired number of children among women of reproductive age (WRA 15–49 years) is 3.8. The average desired number of children among younger women of reproductive age is lower, especially among urban residents and those with higher education, at 3.4 and 3.1, respectively[6].

Improving access to high-quality reproductive health (RH) and family planning services has the highest-level political support in Tajikistan. In 2002, the president called for lowering population growth as a key measure for improving both family health and the economic situation in the country. At the same time, he cautioned against coercive use of contraception and advocated for holistic approaches to improving the quality of and access to RH/FP services. Reportedly, local Islamic authorities are also very supportive of RH/FP interventions. Tajikistan demographic survey (DS) 2002 data demonstrate very high levels of knowledge of modern contraceptive methods: 89.1 percent and 96.7 percent, respectively, among all women and currently married women. And although a multiple indicator cluster survey (MICS) in 2005 documented a substantial increase in the use of modern contraceptives, the use of hormonal and permanent methods among married women remains very low. According to the DS 2002 data, the main reasons for not using contraceptives among all women were “not married” (45 percent), followed by “relying on breastfeeding” (10.6 percent), and “not sexually active” (5.4 percent). Key reasons did not include high price (0.8 percent), inaccessibility (0.2 percent), fear of side effects (0.1 percent), or religion (0.3 percent).

Abortion services in Tajikistan are available without restriction during the first 12 weeks of gestation. Beyond this gestational age, abortion services are available only on medical and selected socioeconomic grounds. Induced abortion remains a primary tool for fertility control in the country. Anecdotal reports indicate that, although induced abortion is officially free of charge, the unofficial cost for an abortion is around US$ 15 in urban areas and US$ 7 in rural areas. DHS 2002 data specify that 72.3 percent of all pregnancies end in a live birth and, on average, 12.6 percent of women use induced abortion for birth control. Reportedly, there are high numbers of illegal abortions and high maternal morbidity and mortality attributable to induced abortion. For example, according to the MOH (1996), about 20 percent of maternal mortality cases are a direct result of induced abortions. A priority should be to explore reasons women resort to illegal abortion when services are legally available.

Tajikistan’s main reproductive health indicators are summarized in Table 1, Annex II.

[6] Tajikistan Demographic Survey 2002.

III. TEN BEST PRACTICES IN FAMILY PLANNING: TAJIKISTAN

The following describes the situation in Tajikistan regarding each of the 10 best practices.

BEST PRACTICE #1 – LIBERALIZED PROVISION OF FP SERVICES

Existing regulations allow only obstetrician/gynecologists (ob/gyns) and trained family doctors (FDs) and midwives in the World Bank-sponsored PHC pilot areas to provide family planning counseling, prescribe contraceptives, and insert intrauterine devices (IUDs). Family planning counseling and contraceptives are officially free of charge at all levels of publicly funded health facilities. At the PHC level, this includes rural policlinics and medical houses. The latter two neither have a doctor on staff nor carry contraceptives, but are served by ob/gyns and *akushers* from rural policlinics or central district hospitals. Once a week, an ob/gyn or a trained *akusher* makes a visit to the medical house to provide FP services and distribute contraceptives. The secondary health care level includes central district hospitals, reproductive health centers (RHCs), and maternity houses at the district, regional, and central levels. Specialists are available at this level to provide all basic RH/FP services and donated contraceptives (i.e., pills, IUDs and condoms). Reportedly, there are very few private health care facilities in Tajikistan and they are mostly located in Dushanbe, the capital city.

POTENTIAL FOCUS AREAS

- **Work with the MOH and all interested parties to strengthen the quality of FP services at the PHC level to attract clients to newly established services.**
- **Change policies so that midwives and FDs in all areas of the country can provide family planning services, making them more accessible to clients**

BEST PRACTICE #2 – FAMILY PLANNING COUNSELING, SERVICES, AND CONTRACEPTIVES ARE PART OF THE "BASIC HEALTH BENEFIT PACKAGE"

The BHBP offers condoms, hormonal contraceptives, and IUDs among its "free" services and includes commodities provided through humanitarian assistance. Anecdotal reports suggest that one must typically pay a fee to get ostensibly free FP counseling and contraceptives.

POTENTIAL FOCUS AREAS

- **Work with the MOH and all interested parties to promote transparency in the free provision of publicly and donor-funded FP services and commodities.**
- **Build on the experience of Zdrav*Plus*- and World Bank-sponsored community education activities and conduct public awareness-raising campaigns on the availability of free FP services and contraceptives at publicly funded health facilities.**

BEST PRACTICE #3 – UP-TO-DATE AND EVIDENCE-BASED POLICIES, REGULATIONS, STANDARDS, GUIDELINS AND SUPPORTIVE SUPERVISION SYSTEM ARE IN PLACE

Reportedly, there have been no modifications at the national level to the Soviet model standards and norms for health facilities that provide family planning services. Several years ago, the MOH adopted national family planning service provision guidelines and protocols based on WHO recommendations. The Zdrav*Plus* program used these guidelines and protocols for their in-service FD training but, in general, the MOH neither monitors nor enforces their implementation on a national scale.

There is no system in place for providing supportive supervision to newly trained family planning providers: FDs, nurses, and midwives.

POTENTIAL FOCUS AREAS

- **Work with the MOH, professional organizations, and all interested parties to revise and update existing family planning service guidelines and protocols as appropriate.**
- **Build on the Zdrav*Plus* program experience and assist the MOH in implementation of revised guidelines and protocols on a national level.**
- **Work with the MOH, WHO, and UNFPA to develop modern standards and norms for health facilities that provide family planning services.**
- **Advocate with the MOH for development of an effective and sustainable provider supportive supervision system to strengthen the quality of family planning services at the PHC level.**

BEST PRACTICE #4 – A BROAD RANGE OF FP METHODS ARE AVAILABLE, ACCESSIBLE, AFFORDABLE, AND ACCEPTABLE IN BOTH RURAL AND URBAN AREAS

More than 30 contraceptive products are available in the commercial market in Tajikistan, including oral contraceptives (OCs), IUDs, injectables, condoms, and spermicides. However, few products are affordable to lower income users. Hormonal methods (OCs and injectables) are becoming more popular among young adults, especially those who are married to seasonal migrant workers. More than 90 percent of married WRA, including poor women, acquire their modern contraceptives from publicly funded health care facilities. UNFPA is a major provider of donated contraceptives to the public sector. The latest shipment of UNFPA contraceptives arrived in Tajikistan in January 2006. USAID-donated contraceptives are distributed through the public sector in pilot districts where Save the Children's Healthy Family program works.

A Population Services International (PSI) knowledge, attitudes, and practices survey (2006) documented widespread misperceptions about OCs among WRA. Allegedly, many FDs and ob/gyns also had negative attitudes about hormonal methods. According to PSI's assessment, pharmacists were the sole source of positive information about OCs for their customers.

There are conflicting reports on the regular availability of contraceptives in the public sector. In contrast to findings from the Tajikistan demographic survey of 2002 and UNFPA's Reproductive

Health and Contraceptive Security (RHCS) assessment of 2006, both DELIVER/PSP-*One*'s 2006 and UNFPA's RHCS 2005 contraceptive security studies reported chronic shortages of contraceptives in the public sector, particularly in rural areas.

The baseline assessment performed by the USAID-funded Healthy Family project in 2003 found that about 12 percent of married women with at least one child were using LAM for contraception. The Healthy Family project is providing LAM training and promotes the method in five districts in Khatlon oblast.

In a country where women complete their families at a young age, most of the population lives in rural areas with limited access to services, and many husbands are absent for long periods of the year, the use of permanent methods of contraception would seem to be attractive for many couples. Reportedly, there is increasing interest among both providers and clients in permanent methods, specifically interval sterilization[7] for women. In 2005, in response to a request from health authorities in Soghd oblast, UNFPA conducted provider training in counseling and the minilaparotomy technique of voluntary female sterilization (VFS) in seven districts of the oblast. VFS services are provided at secondary level hospitals (i.e., central district and city hospitals). Still, this method does not seem to be popular among WRA. Although the actual number of VFS cases performed could not be obtained, according to the central medical statistics department at the MOH, only 0.4 percent of WRA used VFS in 2006. Training in no-scalpel vasectomy has not been performed in Tajikistan since 2003. Anecdotal reports suggest that male sterilization is unpopular due to religious and traditional Tajik beliefs.

POTENTIAL FOCUS AREAS

- **Build on the experience of USAID, Zdrav*Plus*, Mercy Corps, CARE, and World Bank-sponsored community education activities and conduct innovative public information, education, and communication campaigns on modern methods of contraception to dispel misperceptions about hormonal methods.**
- **Work with the MOH, UNFPA, and other interested parties to study the reasons for contraceptive shortages in public-sector clinics and help improve systems for delivery and distribution of contraceptives to users, especially in rural areas.**
- **Study reasons for low utilization of VFS services and develop a plan to eliminate service barriers.**
- **Coordinate with UNFPA and use its trained specialists to provide training in VFS counseling and surgical minilaparotomy technique for providers in USAID pilot regions.**
- **Provide appropriate equipment and medical commodities to enhance VFS service provision.**
- **Consider a study tour to another country (preferably a Muslim country) to demonstrate an effectively functioning VFS program.**
- **Conduct contraceptive technology updates for service providers.**
- **Conduct pharmacist training to enable them to provide their customers with accurate and concise information on modern methods of contraception.**

[7] This term refers to period between two consecutive pregnancies (in contrast to post partum or post abortion period).

- **Breastfeeding is widely practiced in the country. As a contraceptive method that is not dependent on supply, LAM has good potential for increased use, especially in rural areas. Work with the MOH and advocate for:**
    - **a) Scaling up LAM promotion and provider training from the USAID pilot sites in Khatlon oblast.**
    - **b) Inclusion of the LAM training in the pre- and in-service training curricula for service providers.**

BEST PRACTICE #5 – SPECIAL PROGRAMS IN PLACE DESIGNED TO MEET THE NEEDS OF VULNERABLE TARGET GROUPS

Family planning services and contraceptives for the poor are provided at primary and secondary clinics, officially free of charge. Under the USAID CAPACITY project, PSI conducted social marketing of condoms and effectively supplied commodities to outlets serving high-risk youth, prostitutes, and injecting drug users (IDU). The Global Fund supplies condoms for its HIV/AIDS prevention programs, the primary focus of which is high-risk groups of IDUs and prostitutes. Secondary target audiences are prisoners, migrants, and street children.

With funding from the European Union, CARE Tajikistan implements a project to improve access to sexual and RH/FP service for youth in Dushanbe and two other districts. The project components include establishment of youth-friendly clinics and counseling services and education to improve individual knowledge, attitudes, and key behaviors. The specific target groups are vulnerable youth populations, including out-of-school young women and girls, migrant workers, conscripts, the poor, those living in group homes; prostitutes; street children; and IDUs.

POTENTIAL FOCUS AREAS

- **Collaborate with other donor-sponsored programs and the MOH to build on existing experience and advocate for development and allocation of funds for national family planning service programs specifically targeted to high-risk youth, prostitutes, and IDUs.**
- **Work with the MOH, local health authorities, UNFPA, and all interested parties to raise awareness in poor populations, especially in rural areas, about the availability of free family planning services and commodities at publicly funded clinics.**
- **Explore reasons that women resort to illegal abortion when legal services are available, as well as factors contributing to abortion's negative impact on maternal mortality and morbidity.**

BEST PRACTICE #6 – FAMILY PLANNING IS PART OF PRE- AND IN-SERVICE TRAINING PROGRAM FOR HEALTH CARE PROVIDERS

Ob/gyns receive their pre-service training in family planning at the Medical University through the old Soviet style ob/gyn curriculum, which does not have a counseling component and provides cursory information on contraceptive methods. There is no functioning national continuing medical education (CME) system in place. As in the old Soviet system, the State

Institute for Advanced Medical Education offers a three-month advanced ob/gyn training course, including a family planning module, which doctors have to take every three years.

The Zdrav*Plus* project collaborated with the World Bank-sponsored PHC program to incorporate FP counseling and service delivery training modules into the FD re-training curricula. The Zdrav*Plus* project has also piloted in-service training in FP for FDs and CME components in project areas.

POTENTIAL FOCUS AREAS

- **Work with the MOH, Medical University, professional organizations, and other interested stakeholders to revise and adopt evidence-based national pre-service and in-service family planning training curricula for service providers.**
- **Build on the USAID-funded Zdrav*Plus* experience and advocate with the MOH to include family planning training in the CME training system.**

BEST PRACTICE #7 – CONTRACEPTIVE SECURITY IS ENSURED THROUGH ADEQUATE PLANNING WITHIN THE GOVERNMENT

Contraceptives are included in the essential drug list, but the government of Tajikistan does not have the experience of purchasing contraceptives. The DELIVER and PSP-*One* 2006 contraceptive security assessment report concludes that "prospects for financial support for the purchase of contraceptive commodities from the central government are very unlikely and not worth pursuing in either the short or long term." Further, the assessment also indicates that supplies of contraceptive commodities in most public facilities, where family planning services are primarily delivered, are unreliable due to "shortcomings in the contraceptive distribution system, product leakage, and other management weaknesses." There is no country coordination mechanism for working on contraceptive security issues. The authors of the report propose that, even with adequate supply of donated contraceptives, "future sustainability of contraceptive supplies in Tajikistan requires they be included in alternative financing schemes such as revolving drug funds." [8]

There is no contraceptive logistics management information system (LMIS) on the national or local level that tracks consistency in the system and reports to a central coordinating level. UNFPA has supported the development of a LMIS, pilot-tested in two oblasts, that tracks contraceptive storage and distribution from the oblast level down to the districts. While no independent evaluation of this LMIS is available, the UNFPA 2006 RHCS assessment report states that the system functions well and no shortages or expirations of contraceptive commodities were encountered.

POTENTIAL FOCUS AREAS

- **Explore opportunities for including contraceptives in functioning revolving drug funds in USAID-funded project sites.**
- **The USAID-funded DELIVER project improves contraceptive commodity supply chains by strengthening LMIS, identifying financial resources for procurement and**

[8] Contraceptive Security in the Central Asian Republics: Kazakhstan, Kyrgyzstan, and Tajikistan. Fall 2006. Washington, D.C.: DELIVER and PSP-*One* projects for USAID, pp.83-85.

supply chain operation, and enhancing forecasting and procurement planning. Collaborate with UNFPA and the MOH to introduce USAID DELIVER-based contraceptive LMIS in selected pilot sites.

- **Work with the MOH and advocate for institutionalization of the modified (DELIVER and UNFPA) contraceptive LMIS on a national level.**
- **Consider a study tour to Kyrgyzstan to demonstrate an effectively functioning contraceptive LMIS on both the local and national levels.**

BEST PRACTICE #8 – ADOPTION OF A "CULTURE" THAT PROMOTES FAMILY PLANNING COUNSELING

President Rahmonov's strong support for the promotion of high-quality reproductive health and family planning services has given significant impetus to liberalizing family planning service provision from specialty care to the primary care level. This political support has also helped change provider attitudes towards more liberal availability of family planning counseling and services. Over the past several years, USAID and other donors have applied considerable resources to train service providers, raise public awareness about the benefits of family planning, and make modern contraceptive commodities available to all population groups. Still, much remains to be done to make family planning counseling and a wide selection of methods available consistently nationwide.

POTENTIAL FOCUS AREAS

- **Conduct a needs assessment to determine the most useful inputs to enhance availability of improved FP counseling and commodity supply.**

BEST PRACTICE #9 – FP IS ACTIVELY PROMOTED THROUGH SOCIAL MARKETING AND BEHAVIOR CHANGE/SOCIAL MOBILIZATION EFFORTS

In collaboration with JSI and as part of the CAPACITY HIV prevention program, PSI manages social marketing of the "Favorite" condom brand, focusing on high-risk groups including IDUs, prostitutes, and their clients.

POTENTIAL FOCUS AREAS

- **Build on PSI's experience and explore opportunities for partnership with Gedeon Richter and social marketing of its reasonably priced generic oral contraceptive products, especially to reach poor populations in rural areas.**

BEST PRACTICE #10 –A WELL FUNCTIONING NATIONAL HEALTH MANAGEMENT INFORMATION SYSTEM COLLECTS, ANALYSES AND USES FP DATA

Service statistics are manually registered at all clinics offering family planning services and submitted to district RHCs. Data is further compiled at *oblast* FP centers for submission to the Central RHC. Initial calculations of commodity use and forecasting are done at the district level.

Based on information obtained from the *oblasts*, the Central RHC submits contraceptive procurement requests to UNFPA. After obtaining approval from UNFPA, *oblast* RHCs obtain commodities from the central UNFPA warehouse and distribute them to the district and local levels.

Likewise, health statistics from all clinics are accumulated at the district and *oblast* levels and submitted to the Department of Medical Statistics (DMS) at the MOH. The DMS analyzes the data and produces an annual report on the Health Status of the Population in the Republic of Tajikistan.

USAID's Zdrav*Plus* project has been collaborating with the Finance and Medical Statistics Departments of the MOH to create hospital and outpatient clinical and financial health information systems. This will eventually support the new inpatient and outpatient provider payment systems by providing clinical and financial information to help government accurately calculate the cost of health care. Government will then be better able to determine the extent of services it can reasonably include in a guaranteed health benefit package.

POTENTIAL FOCUS AREAS

- **Explore the possibility of including family planning service utilization data in the clinical database program developed by Zdrav*Plus*.**
- **Build on the Zdrav*Plus* experience and conduct awareness-raising workshops and trainings for health authorities at the national and local levels to demonstrate the benefits of evidence-based decision making for increasing effectiveness and efficiency of family planning and other preventive health programs.**

ANNEX I

FAMILY PLANNING PROGRAMS FUNDED BY USAID AND OTHER DONORS

USAID

ZDRAV*PLUS* PROJECT (2004–2009)

Zdrav*Plus* FP activities in Tajikistan are focused on provider training including:

- Development of FP training modules and cooperation with the World Bank-sponsored pilot PHC program to incorporate the modules into the FD re-training curricula
- Inclusion of FP training in antenatal care courses
- Incorporation of FP into activities to prevent sexually transmitted infections

PROJECT HOPE / SAVE THE CHILDREN (2004–2007)

Under the Healthy Family program, training in FP counseling and methods, including IUD insertion and removal, was provided to midwives and *feldshers* at village-level PHC health facilities.

POPULATION SERVICES INTERNATIONAL

PSI implements social marketing of FP services in rural Tajikistan and Kyrgyzstan. The planned intervention has two main components:

1) **Improving access** to contraceptives through:
    - The introduction of affordable OCs, injectables, IUDs, and emergency contraception
    - Promotion of and referral to existing points of contraceptive supply and services
    - Training and supply of village-level health providers to enable contraceptive provision where no pharmacies exist
    - Training of providers and supply of contraceptives through “health houses”

2) **Increasing informed demand** for contraceptives through intensive interpersonal communications to:
    - Raise awareness about the benefits of contraceptive use
    - Dispel misconceptions about their side effects
    - Provide information on available methods

THE CAPACITY PROJECT (2004–2009)

CAPACITY Project is seeking to build Central Asian technical capacity to launch large-scale and urgent responses to HIV and AIDS, and to develop indigenous institutions and networks that can develop and manage the comprehensive HIV control programs.

UNFPA (2005–2009)

UNFPA support to Tajikistan was initiated under a sub-regional program between 1995 and 1999. The first country program was implemented in the period 2000–2004. However, UNFPA has procured contraceptives for the public sector in Tajikistan since 1993 for distribution through reproductive health clinics. Due to funding constraints, there was an interruption of supply in 2000–2001; a gap partially filled by DFID. Currently, the UNFPA project supplies free contraceptives to RH clinics and PHC facilities in Sogd and Khatlon oblasts. The RH clinics are located within general healthcare facilities. UNFPA's reproductive health program has two components:

1) Improved availability of high-quality, gender-sensitive reproductive health information, counseling, and services—including family planning and HIV/AIDS prevention—through enhanced institutional and technical capacities of the government and NGOs
2) Enhanced awareness and understanding of adolescents of their sexual and reproductive health needs and rights[9]

EUROPEAN UNION

CREATING AN ENABLING ENVIRONMENT FOR IMPROVING SEXUAL AND REPRODUCTIVE HEALTH FOR YOUTH (2006–2009): CARE TAJIKISTAN

The overall objective of the project is to improve sexual and reproductive health in Tajikistan through improved access to, use of, and advocacy for sexual and reproductive health services among youth. To accomplish these objectives, CARE will concentrate on achieving the following principal results:

1) Increased access to youth-friendly clinics and counseling services
2) Improved knowledge, attitudes, and key behaviors of individual youth on sexual and reproductive health issues
3) An improved policy and social environment for youth sexual and reproductive health

Program target groups are vulnerable youth populations including out-of-school young women and girls, migrant workers, conscripts, those living in group homes, sex workers, street children, and IDUs.

[9] http://www.unfpa.org/cp/tjk/tjk0509.pdf

AGA KHAN FOUNDATION (AKF)

AKF has had programs in Tajikistan since 1997. It includes FP in its community mobilization and community health education activities. AKF collaborates with the MOH and public-health facilities and uses trained village health educators to provide information to village communities on different methods of FP, including those available in the public sector. AKF works in 11 districts of Gorno Badakhshan oblast and four districts of Khatlon oblast, in total covering 470 villages.

CANADIAN INTERNATIONAL DEVELOPMENT AGENCY (CIDA)

MERCY CORPS (June 2006–March 2010)

Under its poverty reduction program, Mercy Corps (MC) conducts community mobilization and community education on birth spacing and directly distributes condoms. MC trains community workers, preferably with a health background, who provide information to village communities on available methods of contraception and refer interested clients to public-health facilities. MC cooperates with AKF and covers more than 100 villages in four districts.

ANNEX II

REPRODUCTIVE HEALTH INDICATORS: TAJIKISTAN

Table 1. Reproductive Health Indicators: Tajikistan

Indicator	Parameter
Total population	6.5 million
Population growth rate	0.9%
Women of reproductive age 15–49, (thousands)	1,681.4
Total fertility rate among WRA, 15–49 years (UNFPA 2006)	3.06
Contraceptive prevalence rate among married women, all methods*	**38.0%**
➢ Traditional methods (total) *	**4.9%**
➢ Modern methods (total)	**33.1%**
IUD	26.3%
Injectable	2.4%
Condom and injectables	1.4%
Pill	2.1%
Female sterilization	0.4%
Male sterilization and vaginal methods	0.9%
Reasons for not using modern methods, all women **	
- fear of side effects**	0.1%
- lack of knowledge**	0.3%
- cost**	0.8%
- lack of access**	0.2%
- religion* *	0.3%
- partner opposes**	1.1%
Unmet need for modern contraception	†
Total abortion rate per WRA ** / in Dushanbe (capital city)	2.02 / 2.54
Receipt of post abortion FP counseling	†
- received a contraceptive method or prescription	†
Maternal morbidity rate attributable to abortion	†
Receipt of postpartum FP counseling	†
Infant mortality (per 1,000 live births)*** (2005)	59
Maternal mortality (per 100,000 live births)****	100
HIV prevalence *****	0.1
- estimated number of HIV cases in 2006 ****	6,800

Sources: *MICS Tajikistan 2005; **Demographic Survey Tajikistan 2002;
*** UNICEF http://www.unicef.org/infobycountry/Tajikistan.html accessed 3. 04.07
**** UNFPA http://www.unfpa.org/profile/tajikistan.cfm accessed 3.04.07
*****UNAIDS http://www.unaids.org/en/Regions_Countries/Countries/tajikistan.asp accessed 3.04.07
† This information is not available at this time.

ANNEX III

KEY INFORMANTS INTERVIEWED

Zdrav*Plus* Project

Gita Pillai, PhD, MPH	Regional Deputy Director, Zdrav*PlusII* Project Regional Director, Maternal and Child Health JSI Research & Training Institute, Inc.

The CAPACITY Project

Audrey Seger Sprain	Regional Operations Director JSI Research & Training Institute, Inc.
Leila Koushenova	Project Coordinator Population Services International

Project HOPE

Sarah E. Porter, MPH	Project Director/Chief of Party Healthy Family Program (Tashkent, Uzbekistan)
Shodiya Mirkhaidarova	Program Manager Save the Children, Healthy Family Program (Tajikistan)

CARE Tajikistan

Khursheda Rakhmatova	Program Manager CARE Tajikistan

Aga Khan Foundation

Dr. Ervin	Project Coordinator

Mercy Corps

Dalatmo Usufbekova	Monitoring and Evaluation Manager

ANNEX IV

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